PLAN FIRST AGREEMENT / ENROLLMENT FORM

The completion of the attached form is necessary to ensure the provider's understanding of the acceptance of program requirements including, but not limited to the oral contraceptive distribution system.

Please complete all required blanks and sign where indicated. If you are enrolled for a clinic, please indicate based on the following instructions:

1. I _____ - indicate the physician or clinic name.
2. **Executed - indicate the date you sign the contract.**
3. Signature - should be signed by the physician. If a clinic provider, the person responsible for clinic administration (e.g. chief of staff, business office manager, etc.) should sign.
4. Title - indicate whether this is the physician or the relationship of the signee to the clinic.

Enrollment

1. Please indicate this information, as it appears on the EDS file including your physical address.
2. The provider number is the number of the physician or clinic.
3. Contact - please indicate who should be called when questions about the program arise.

The completed form should be returned to:

EDS Provider Enrollment
Attn: Enrollment
P.O. Box 244035
Montgomery, AL 36124

AGREEMENT FOR PARTICIPATION IN THE PLAN FIRST PROGRAM

I _____ hereby enter into an agreement with the Alabama Medicaid Agency for participation in the Plan First.

I agree to provide services as described in the family Planning, Plan First Application of the Alabama Medicaid Provider Manual and in accordance with the terms and conditions expressed in the Medicaid State Plan for Medical Assistance, the Administrative Code, the approved 1115 Research and Demonstration Waiver and all other federal and state laws and regulations as they pertain to my performance under this agreement. I understand that these requirements are incorporated by reference into this agreement. I understand that I am bound to follow all specifications, terms and conditions expressed in these manuals and documents, and that my failure to do so may result in termination of this agreement and recoupment of any or all funds paid under this agreement.

I further agree that oral contraceptives provided to recipients enrolled in Plan First will be dispensed directly to them. Therefore, this agreement also serves as an agreement with the Alabama Department of Public Health (ADPH) to receive oral contraceptives at no cost. On behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural clinic, or other entity of which I am acting "physician-in-chief" or equivalent, I agree to the following:

1. ADPH supplied oral contraceptives will be dispensed only to women age 19-44 who are Medicaid Plan First participants. No more than a 12-month supply (13 packs) will be provided at one time.
2. I will comply with the ADPH's requirements for ordering oral contraceptives.
3. I understand the ADPH retains the right to validate and account for the oral contraceptives.

Executed this _____ day of _____, 200___.

_____
Signature

_____ _____
Title Typed / Printed Name

Enrollment Information

Name: _____

Address (including street address and county) _____

City _____ Zip:_____ Provider #:_____

Office Phone: _____ FAX#: _____

Type of Enrollment: _____Group _____ Individual

Group or Clinic Name:_____

Group/Payee Number : _____ Contact Name: _____

FOR EDS USE ONLY

Date Accepted: _____ By: _____ Indicator Added: _____